Waverly Child Care & Preschool - Medication Release

Name of Child:							
Name of Medication:							
		ication:			the state of the s		
	Number of Days/Doses:						
		dication (ear, eye, oral, rectal, top					
Signature of I							
	ature of Parent or Guardian:				Date:		
	Date	Child's Name	Medication	Dose	Time Given	Staff Initials	
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						And the state of t	
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Staff Signatures:							
			* **				